MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

DATA CLARIFICATIONS FOR THE 837 INSTITUTIONAL CLAIM, VERSION 4010

January 30, 2002

Michigan Department of Community Health

MDCH

MSA MEDICAL SERVICES ADMINISTRATION

This document is intended as a companion to the **National Electronic Data Interchange Transaction Set Implementation Guide, Health Care Claim: Institutional Claim, ASC X12N 837 (004010X096)**, dated May 2000. It contains data clarifications authorized by the Department of Health and Human Services (HHS) on September 17, 2001. The clarifications include:

- identifiers to use when a national standard has not been adopted [and]
- parameters in the implementation guide that provide options

(The implementation guide can be found at http://www.wpc-edi.com/hipaa/hipaa_40.asp. HHS guidance on data clarifications can be found at http://aspe.os.dhhs.gov/admnsimp/q0321.htm.)

Page	Loop	Segment	Data Element	Comments
60		REF	REF02 – Transmission Type Code	Use “004010X096” if using May 2000 IG.
63	1000A	NM1	NM109 – Submitter Identifier	Use the 4-character billing agent ID assigned by MDCH.
68	1000B	NM1	NM109 – Receiver Primary Identifier	Use “D00111” for MDCH.
77	2010AA – Billing Provider Name	NM1	NM108 – Identification Code Qualifier	Use “24” or “34”.
78			NM109 – Billing Provider Identifier	Use the same EIN or SSN value submitted when registering the MDCH provider identifier used in REF02.
83		REF	REF01 – Reference Identification Qualifier	Use “1D”.
84			REF02 – Billing Provider Additional Identifier	Use the 9-digit provider identifier assigned by MDCH (2-digit provider type followed by 7-digit assigned ID).
99	2000B – Subscriber Hierarchical Level	HL		MDCH accepts a maximum of 5000 CLM segments in a single transaction (ST-SE) as recommended by the HIPAA-mandated implementation guide.
102		SBR	SBR01 – Payer Responsibility Sequence Number Code	Use “P” if MDCH is the only payer (that is, patient has no Medicare or other insurance), “S” if there is one other payer, and “T” if there are two or more other payers.
104			SBR09 – Claim Filing Indicator Code	Use “MC” for Medicaid, “TV” for CSHCS (Title V), “11” for State Medical Plan (Other Non-Federal).
110	2010BA – Subscriber Name	NM1	NM108 – Identification Code Qualifier	Use “MI”.
			NM109 – Subscriber Primary Identifier	Use the patient’s 8 character beneficiary ID number assigned by MDCH.
127	2010BC – Payer Name	NM1	NM108 – Identification Code Qualifier	Use “PI”.
128			NM109 – Payer Identifier	Use “D00111” for MDCH.
157	2300 – Claim	CLM		Note that the HIPAA-mandated implementation guide allows a maximum of 100 repetitions of the 2300 CLM loop within each 2000C loop.

Page	Loop	Segment	Data Element	Comments
159			CLM05-3 – Claim Frequency Code	See the Michigan Uniform Billing Manual for acceptable codes (This is the third position of FL04 Type of Bill.) If value is "7" (claim replacement) or "8" (void/cancel), show the MDCH-assigned CRN of the last approved claim as indicated on page 191).
191		REF – Original Reference Number (ICN/ DCN)	REF01 – Reference Identification Qualifier	Use when submitting a claim replacement or void/cancel (as indicated by CLM05-3), use "F8".
192			REF02 – Claim Original Reference Number	Use the 10-character CRN assigned by MDCH to the last approved claim.
197		REF – PEER Review Organization (PRO) Approval Number	REF01 — Reference Identification Qualifier	Use "G4".
			REF02 – Peer Review Authorization Number	Use the 9-character number assigned by the Admission and Certification Review Contractor.
198		REF – Prior Authorization Number	REF01 – Reference Identification Qualifier	Use "G1".
199			REF02 – Prior Authorization Number	Use the 9-character number assigned by MDCH.
208		NTE – Billing Note	NTE01 – Note Reference Code	Use "ADD".
209			NTE02 Billing Note Text	Provide free-text remarks, if needed.
242		HI – Principal Procedure Information	HI01-1 – Code List Qualifier Code	Use "BR" (ICD-9-CM Principal Procedure).
			HI01-2 – Principal Procedure Code	See the ICD-9 CM Code book for acceptable procedure codes.
244 – 255		HI – Other Procedure Information	HI01-1, HI02-1, …, HI12-1 – Code List Qualifier Code	Use "BQ" (ICD-9-CM Procedure).
245 – 255			HI01-2, HI02-2, …, HI12-2 – Procedure Code	See the ICD-9 CM Code book for acceptable procedure codes.

Page	Loop	Segment	Data Element	Comments
256 – 266		HI – Occurrence Span Information	HI01-2, HI02-2, ..., HI12-2 – Occurrence Span Code	See the Michigan Uniform Billing Manual for acceptable codes.
268 – 278		HI – Occurrence Information	HI01-2, HI02-2, ..., HI12-2 – Occurrence Code	See the Michigan Uniform Billing Manual for acceptable codes.
281 – 291		HI – Value Information	HI01-2, HI02-2, ..., HI12-2 – Value Code	See the Michigan Uniform Billing Manual for acceptable codes.
290		HI – Condition Information	HI01-2, HI02-2, ..., HI12-2 – Condition Code	See the Michigan Uniform Billing Manual for acceptable codes.
326	2310A – Attending Physician Name	REF – Attending Physician Secondary Identification	REF01 – Reference Identification Qualifier	Use “1D”.
327			REF02 – Attending Physician Secondary Identifier	Use the 9-digit provider identifier assigned by MDCH (2-digit provider type followed by 7-digit assigned ID).
333	2310B – Operating Physician Name	REF – Operating Physician Secondary ID	REF01 – Reference Identification Qualifier	Use “1D”.
334			REF02 – Operating Physician Secondary Identifier	Use the 9-digit provider identifier assigned by MDCH (2-digit provider type followed by 7-digit assigned ID).
340	2310C – Other Provider Name	REF – Other Provider Secondary Identification	REF01 – Reference Identification Qualifier	Use “1D”.
341			REF02 – Other Provider Secondary Identifier	Use the 9-digit provider identifier assigned by MDCH (2-digit provider type followed by 7-digit assigned ID).
357	2310E – Service Facility Name	REF – Service Facility Secondary Identification	REF01 – Reference Identification Qualifier	Use “1D”.
358			REF02 – Laboratory or Facility Secondary Identifier	Use the 9-digit provider identifier assigned by MDCH (2-digit provider type followed by 7-digit assigned ID).
359	2320 – Other Subscriber Information	SBR – Subscriber Information		If the patient has Medicare or other insurance, repeat this loop for each other payer. Do not put information about MDCH coverage in this loop.

Page	Loop	Segment	Data Element	Comments
360			SBR01 – Payer Responsibility Sequence Number Code	If the patient has Medicare, report that coverage with code "P" and any other insurance with codes "S" or "T" as appropriate. If the patient does not have Medicare, report each coverage with code "P", "S", or "T" as appropriate.
361			SBR02 – Individual Relationship Code	The code carried in this element is the patient's relationship to the person who is insured. For example, if a child with Medicaid has coverage under his father's insurance, use code 19 (Child).
363			SBR03 – Insured Group or Policy Number	Use the subscriber's group number (assigned by the other payer), not the number that uniquely identifies the subscriber. For example, group numbers assigned by BCBSM are usually 5 digits.
			SBR09 – Claim Filing Indicator Code	Do not use "MC" or "TV" in this element.
401 - 402	2330A – Other Subscriber Name	NM1	NM103, NM104, NM105 – Other Insured: Last Name, First Name, Middle Name	Use the name of the subscriber as it appears on the files of the other payer.
			NM108 – Identification Code Qualifier	Use "MI".
403			NM109 – Other Insured Identifier	Use the unique member number assigned to the subscriber by the other payer indicated in loop 2330B. For example, member numbers assigned by BCBSM are usually 3 letters followed by 9 digits.
408		REF – Other Subscriber Secondary Information	REF01 – Reference Identification Qualifier	Do not use "1W".
411	2330B – Other Payer Name	NM1	NM108 – Identification Code Qualifier	Use "PI".
			NM109 – Other Payer Primary Identifier	Use the 8-digit carrier code assigned by MDCH (see MDCH website for listing of carrier codes). For example, if Blue Cross/ Blue Shield of Michigan Traditional was the Other Payer, the value (carrier code) carried in this element would be 00029005.
426	2330D – Other Payer Attending Provider	REF – Other Payer Attending Provider ID	REF01 – Reference Identification Qualifier	Do not use "1D".
430	2330E – Other Payer Operating Provider	REF -- Other Payer Operating Provider ID	REF01 – Reference Identification Qualifier	Do not use "1D".

Page	Loop	Segment	Data Element	Comments
434	2330F – Other Payer Other Provider	REF -- Other Payer Other Provider ID	REF01 – Reference Identification Qualifier	Do not use “1D”.
438	2330G – Other Payer Referring Provider	REF -- Other Payer Referring Provider ID	REF01 – Reference Identification Qualifier	Do not use “1D”.
442	2330H – Other Payer Service Facility Provider	REF – Other Payer Service Facility Provider ID	REF01 – Reference Identification Qualifier	Do not use “1D”.
444	2400 – Service Line			MDCH recommends submitting 50 or fewer service lines for each institutional claim. Claims submitted with more than 50 service lines may be subject to processing delays.
446			SV201 – Service Line Revenue Code	See the Michigan Uniform Billing Manual for acceptable codes.
447			SV202-2 – Procedure Code	See the Michigan Uniform Billing Manual for acceptable codes.
490	2430 – Service Line Adjudication Information			MDCH expects this loop for each payer identified in loop 2320, except when that payer has adjudicated this claim at the claim level.